GROWN UP™...

A Newsletter For Those Who Care For

ADOLESCENTS, ADULTS AND AGING ADULTS

Volume 9, No. 12, December, 2004

AGE-SPECIFIC PAIN RESPONSES & ASSESSMENT

Editor in Chief: Mary Myers Dunlap, MAEd, RN

Behavioral Objectives: After reading this newsletter the learner will be able to:

1. **Describe typical age-specific pain responses of adolescents, adults and aging adults**
2. **Discuss population-specific pain assessment, as well as 4 behavioral responses to pain.**

Pain is experienced by patients of all ages. Over 34 million Americans—aging adults, adults, adolescents and children, suffer from pain. Pain is the most common reason patients of all ages give for seeking medical care.

There is no simple definition of pain. Pain is whatever the person experiencing the pain says it is, existing whenever the patient says it does. Although pain is a subjective and personal experience, patients in various age-groups have characteristic responses to pain.

This newsletter will examine the concept of pain and typical age-specific pain responses. Behavioral responses to pain, as well as population-specific pain assessment, will also be discussed.

PAIN

Because pain is an individual experience, patient self-reporting is the single most reliable indicator of the existence and intensity of pain. Tolerance to pain varies from person to person, and from time to time in the same person. Regardless of the cause, pain as the person perceives it, is what must be managed. The individual who is experiencing the pain is the judge of the severity of pain, and the relief of pain.

Certain types of pain are more common in certain age-groups. Chronic pain, continuous or regularly occurring pain, that extends over a period of 6 months or longer, is more common in aging adults. Acute pain, from tissue damage caused by disease, injury, surgery or other invasive procedures, is common in all populations. It is relatively short-lived and can range in intensity from tolerable to extreme.

AGE-SPECIFIC PAIN RESPONSES

ADOLESCENTS:

Adolescents, 12-18 years old, typically show less vocal and behavioral protest to pain. "It hurts" or "You're hurting me" are common verbal expressions. Much self-control is usually evident. However, adolescents may withhold or exaggerate their reaction to pain according to who is present. For example, teens usually have less of a reaction to pain around peers and more when family members are present.

Adolescents commonly view an illness, injury and treatment in terms of how their body image, their appearance, will be affected, rather than the degree of the associated pain. Any change to their body, such as sutures, and the potential of scarring, which will make them look different from their peers can be devastating to the adolescent.

ADULTS:

Young and middle adults experiencing pain are usually able to interpret its origin and possible cause. However, most adults see pain as a threat to their safety and are typically anxious. For example, they may worry whether a persistent headache is a sign of something more serious, such as a brain tumor.

One of the first indications of pain in adults may be that they withdraw, from family members and healthcare providers. If adults are angry or afraid about being in pain, they may curse, complain loudly, talk incessantly about their agony or ask for help. If pain has been anticipated, such as that post-operatively, reactions are usually less intense then when pain is not expected.

AGING ADULTS:

There is no evidence that elderly persons perceive pain differently from younger persons. Although aging adults are not less sensitive to pain, they generally report pain less often than adults or adolescents, for a number of reasons.

Many older adults, their family members, as well as healthcare providers believe pain is a natural occurrence with aging. Although elderly patients do develop more chronic diseases as they age, pain is not an expectation of normal aging. The elderly may fear pain indicates worsening of a disease and, therefore, may not report it. Aging adults may also fear drug therapy, particularly opioids, will cause addiction, as well as adverse effects, such as confusion, constipation, sedation and dizziness. Healthcare professionals may also mistakenly fear the side effects of opioids, such as respiratory depression, leading to under-treatment of pain. The elderly patient may take a mild analgesic, then discontinue it because "it did not help". Assuming that anything stronger may be "addicting," the patient accepts the pain as inevitable. The patient's beliefs about the use of pain medication should be examined, especially myths about addiction.

Aging adults may also not complain of pain to avoid undergoing painful procedures. Additionally, elders may feel that being stoic and refusing to "give in" to pain are appropriate behaviors.

Many older patients will not report pain because they "don't want to bother anyone" or to complain. Elderly patients may not bring pain to the attention of the healthcare providers because they fear being labeled as bothersome or a hypochondriac.

Many older adults believe that healthcare providers should know when they're in pain and believe everything possible is already being done to help them. Some elder patients may feel their pain will not be believed or that nothing is going to help. They'll just "have to live with it".

Healthcare providers must consider these age-specific responses, which commonly become barriers to assessing pain in the elderly. Additionally, accurate pain assessment and effective pain control may also be impeded by age-related changes in the older adult, including hearing and visual impairments, as well as dementia. In patients with such impairments, special attention must be paid to nonverbal cues, behavioral responses to pain. For example, someone with dementia, who is unable to ask for analgesia, may express pain by grimacing, moaning, crying out, or resisting a caregiver's attempts to move his or her body.

BEHAVIORAL PAIN RESPONSES

Regardless of the patient's age, certain behavioral responses may indicate pain. These include:

- Facial grimaces
- Bracing/ Guarding
- Favoring one limb
- Rubbing the painful site
- Clenching of teeth or fists
- Restlessness/Anxiety
- Increased heart and respiratory rate
- Sweating
- Decreased appetite
- Sighing
- Sadness
- Crying/Screaming
- Insomnia
- Decreased activity/ mobility
- Making demands

Remember, objective data is not as reliable as a self-report of pain. Therefore, behavioral signs of pain warrant further assessment.

Population-Specific Pain Assessment:

NUMERIC PAIN SCALE: With a 0-10, or 0-5, numeric pain scale, patients should rate their current pain using numbers, with zero representing the least amount of pain possible, and 10 (5) representing pain as bad as it can be.

10 Point Numeric Scale

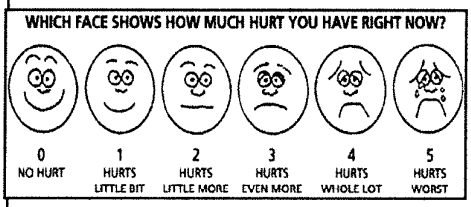
No Pain — Worst Pain

0 2 4 6 8 10

Number scales can be useful for non-English speaking patients, once explained in the patients' language.

Many elderly, especially those with dementia or confusion, relate best to pain-measuring scales which include word scales like "mild, moderate, or severe" and the happy-to-sad FACES scale, traditionally used for children. Regardless of the scale being used, ensure that any needed aids for hearing and seeing are available to the patient. Also, speak slowing and clearly, facing the patient. If an elderly patient is unable to communicate, assume that known painful procedures, such as surgery, will result in pain, and treat it accordingly. In such cases, evaluation of the patient's response may need to be based on behavioral indicators.

THE FACES SCALE (Wong & Baker): The Wong-Baker FACES rating scale, traditionally used in young children, consists of 6 faces ranging from a very happy, smiling face depicting "no pain" to a tearful, sad face depicting "worst pain". It also has a numeric scale, 0–5, corresponding to the faces and word descriptions.

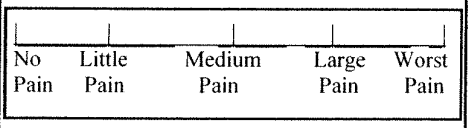


From Wong, D.L., Hockenberry-Eaton, M., Wilson, D., Winkelstein, M.L., Ahmann, E., DiVito-Thomas, P.A.: Whaley and Wong's Nursing Care of Infants and Children, ed. 6, St. Louis, 1999, p. 2040. Copyrighted by Mosby, Inc.

The healthcare professional or family member should point to each face using the words to describe the pain intensity.

The aging adult should be asked to choose the face that best describes his or her own pain. The corresponding number should, then, be recorded on the pain record.

VERBAL-DESCRIPTOR SCALE: This pain rating scale uses descriptive words to denote varying intensities of pain. It should be explained to the patient that at one end of the line is no pain, and at the other end is the worst pain. In between are little, medium and large amounts of pain.



Ask the patient to choose a point on the line which represents his or her pain now. Or, ask the patient the word descriptors, "Is your pain medium or is it less or worse than that?" Once the pain intensity is determined, assign a number to it, such as "little pain" is a pain intensity of 2.5; "medium pain" is 5, when based on a 10 point scale.

On-going assessment of pain is essential and should be considered the fifth vital sign. Regular assessment of pain and documentation allows all care providers to see the pain measurement, and pain can be managed according to the patient's on-going responses.

Regardless of the age of the patient, the healthcare provider must accept the patient's report of pain. If behavioral responses to pain are misinterpreted and patients are medicated based on this objective assessment, rather than on self-reports of pain, under-medication may occur.

It is an essential intervention that when a patient reports pain, that it be managed immediately. This is true even during procedure, particularly one that is not life-threatening . Healthcare professionals must be advocates for patients.

Growing Up With Us..., Inc. ©2004
PO Box 52682 Durham, NC 27717
Phone #:919-489-1238 Fax #: 919-493-2196
Editor-in-Chief: Mary Myers Dunlap MAEd, RN
E-mail: mdunlap@nc.rr.com
Website: growingupwithus.com
TestingCenter: www.growingupwithus.com/quiztaker/